REFACS

Original Article
Rev. Fam., Ciclos Vida Saúde Contexto Soc.
http://seer.uftm.edu.br/revistaeletronica/index.php/refacs/index
ISSN: 2318-8413 DOI: 10.18554/refacs.v10i3.5962

Heteronormativity and the health of bisexual women and lesbians in university

A heteronormatividade e a saúde de mulheres bissexuais e lésbicas universitárias

La heteronormatividad y la salud de mujeres bisexuales y lesbianas universitarias

Naiara Regner da Silva[1], Marina Soares Mota[2], Luís Felipe Hatje[3], Victoria Leslyê Rocha Gutmann[4], Carolina Coutinho Costa Vallejos[5], Camila Daiane Silva[6]

Received: 07/12/2021 **Approved:** 23/07/2022 **Published:** 30/09/2022

Objective: to know the perception of lesbians and bisexual and women in university about heteronormativity and its influence on health. **Methods:** descriptive, quali-quantitative study, carried out in the first quarter of 2020, with undergraduate and/or graduate academic lesbians and bisexual women through an online questionnaire. Data were treated by Content Analysis and descriptive statistics. **Results:** 163 women participated, of which 110 declared themselves to be bisexual and 53 lesbians, of which 140 were undergraduate students, aged between 18 and 29 years (93.87%), 57% reported their sexual orientation in health care, and 28.83% did not inform it. On the perceptions of 73.62% of participants, heteronormativity influences health. Two categories were constructed: "*The perception of heteronormativity and the cultural, social and political implications for health*" and "*Heteronormativity and the personal implications for health*". By heteronormativity, we have: damage to health, mental or physical; invisible sexual orientation; lack of advertising campaigns and insufficient knowledge of health professionals, including about sexually transmitted diseases. **Conclusion:** acting more on the health of lesbians and bisexual women is important both in terms of public policies and in a better preparation of the professionals involved.
Descriptors: Sexual and gender minorities; Gender norms; Homosexuality, female; Bisexuality; Delivery of health care.

Objetivo: conhecer a percepção de mulheres bissexuais e lésbicas universitárias sobre a heteronormatividade e sua influência na saúde. **Método:** estudo descritivo, quali-quantitativo, realizado no primeiro trimestre de 2020, com mulheres bissexuais e lésbicas acadêmicas de graduação e/ou pós-graduação por meio de questionário *online.* Os dados foram tratados pela Análise de Conteúdo e estatística descritiva. **Resultados:** participaram 163 mulheres, das quais 110 se declararam bissexuais e 53 lésbicas, das quais 140 eram discentes da graduação, idade entre 18 e 29 anos (93,87%), 57% informavam a orientação sexual nos atendimentos em saúde e 28,83% não informavam. Nas percepções a heteronormatividade influência na saúde em 73,62%. Duas categorias foram construídas: "*A percepção da heteronormatividade e as implicações culturais, sociais e políticas de saúde*" e "*A heteronormatividade e as implicações pessoais em saúde*". Pela heteronormatividade tem-se: danos à saúde, mental ou física; orientação sexual invisibilizada; falta de campanhas publicitárias e conhecimento insuficiente dos profissionais de saúde, inclusive sobre as sexualmente transmissíveis. **Conclusão:** atuar mais sobre a saúde de mulheres lésbicas e bissexuais é importante tanto em termos de políticas públicas, como num maior preparo dos profissionais envolvidos.
Descritores: Minorias sexuais e de gênero; Normas de gênero; Homossexualidade feminina; Bissexualidade; Atenção à Saúde.

Objetivo: conocer la percepción de las mujeres bisexuales y lesbianas universitarias sobre la heteronormatividad y su influencia en la salud. **Método**: estudio descriptivo, cuali-cuantitativo, realizado en el primer trimestre de 2020, con mujeres bisexuales y lesbianas académicas en pregrado y/o postgrado por medio de un cuestionario online. Los datos se trataron mediante Análisis de Contenido y estadística descriptiva. **Resultados:** Participaron 163 mujeres, de las cuales 110 se declararon bisexuales y 53 lesbianas, de las cuales 140 estaban en el pregrado, edad entre 18 y 29 años (93,87%), 57% informaban de la orientación sexual en las consultas de salud y 28,83% no informaban. En las percepciones, la heteronormatividad influye en la salud en un 73,62%. Se construyeron dos categorías: "*La percepción de la heteronormatividad y las implicaciones culturales, sociales y políticas de salud*" y "*La heteronormatividad y las implicaciones personales en salud*". Por heteronormatividad se comprende: daños a la salud, mental o física; orientación sexual invisibilizada; falta de campañas publicitarias e insuficiente conocimiento de los profesionales de la salud, incluso sobre las enfermedades de transmisión sexual. **Conclusión:** actuar más sobre la salud de las mujeres lesbianas y bisexuales es importante tanto en términos de políticas públicas, como en la mayor preparación de los profesionales involucrados.
Descriptores: Minorías sexuales y de género; Normas de género; Homosexualidad femenina; Bisexualidad; Atención a la Salud.

Corresponding Author: Victoria Leslyê Rocha Gutmann - victorialeslye@gmail.com

1. Nurse. Rio Grande/RS, Brazil.
2. Undergraduate Nursing Course at the Universidade Federal de Pelotas – UFPel, Pelotas, RS, Brazil.
3. Graduate Program in Science Education at the Universidade Federal do Rio Grande (FURG), Rio Grande/RS, Brazil.
4. Graduate Nursing Program at the Universidade Federal d Santa Catarina – UFSC, Florianópolis/SC, Brazil.
5. Graduate Nursing Program at FURG, Rio Grande/RS, Brazil.
6. Undergraduate Nursing Course at FURG, Rio Grande/RS, Brazil.

INTRODUCTION

In addition to the anatomical sex that biologically defines man and woman through their physiognomy, there is gender identity, sexual orientation and gender expression. Gender identity refers to the way a person defines themself, which may be in accordance with the sex at birth, that is, cisgender, or in dissonance with it, that is, transgender. Still, gender identity may not fit the binary and dichotomous gender, so there are also individuals who identify as genderfluid, non-binary or agender[1].

Sexual orientation, in turn, dialogues directly with the expression of sexuality, desire and affective and sexual attraction. Therefore, it can be presented as hetero, homo, bi or pansexual. Heterosexuality is the affective and/or sexual desire for the opposite sex. While homosexuality consists of attraction to people of the same gender, so that a homosexual woman is called a lesbian and a homosexual man is called gay. In addition, there are bisexuals, who are attracted to both females and males. Finally, pansexuals feel affective or sexual attraction regardless of gender[1].

Despite the vast diversity about sexuality, patterns of behavior historically constructed and naturally incorporated into male and female contexts assume the compulsory heterosexuality of individuals, called heteronormativity[2]. Talking about sexuality, body and gender is often a reason for concern, doubts and taboos, so that sexual orientations other than heterosexual are unknown, ignored and even persecuted[3]. Bisexual women and lesbians are doubly marginalized, first for being biologically women, second for being in a hierarchical and normative context of relations of dominance and submission to men, as well as for distancing themselves from the determination of reproduction, breaking the paradigm historically imposed on women[4].

The ways in which bisexual women and lesbians are seen by society reflect in different sectors of their lives, including disease prevention and health promotion[5]. Failures in the reception and preparation of professionals, in addition to prejudice, contribute to the removal of this population from health services. Often, in medical consultations, the patient is assumed to be heterosexual, contributing to the fact that the needs of bisexual women or lesbians are not met or addressed[6].

Therefore, heteronormativity generates direct and indirect consequences for the health of bisexual women and lesbians, such as: menstrual, breast, kidney and bladder problems, cervical cancer, Sexually Transmitted Infections (STIs), use and dependence of alcohol, tobacco and other drugs, anxiety, depression, in addition to the most diverse forms of violence, such as verbal, psychological, physical and even sexual[2].

Thus, despite the achievement of sexual and reproductive rights, such as the Brazilian National Policy for the Comprehensive Health of Lesbians, Gays, Bisexuals, Transvestites and Transsexuals (LGBT+), actions that effectively promote the health of bisexual women and lesbians remain scarce[7]. In this way, the health area, especially nursing, plays a crucial role in the care and visibility of vulnerable populations, since they are the professionals closest to the population in health services. Therefore, their performance can contribute to a service with greater equity and equality in health and in the social environment[6].

It is believed that knowing the perception of bisexual women and lesbians in university about heteronormativity and its influence on health will help to identify the demands of this public, as well as to think about strategies that address their needs in care practices. Thus, this study aims to understand the perception of bisexual women and lesbians in university about heteronormativity and its influence on health.

METHODS

This is a descriptive, exploratory, qualitative-quantitative research, developed through a structured questionnaire with multiple choice and open-ended questions, available online on the Google Forms® platform. The research had as a guiding question: *What is the perception of bisexual women and lesbians in university about heteronormativity and its influence on their health?*

Google Forms is a free tool, compatible with any browser and operating system, which allows the construction of forms with discursive or multiple choice questions. The access link was publicized on social media, such as Instagram® and Facebook®. This format was chosen, since potential participants could not be included in the study due to the need to affirm their sexuality, in addition to the difficult mapping, due to social and cultural issues, of who these potential participants would be.

The study included female undergraduate or graduate academics, over 18 years of age and who defined themselves as bisexual or lesbian. Women who defined themselves as heterosexual, younger than 18 or older than 60 years and men were excluded. The time of availability of the online questionnaire was limited to three months, from the release of the opinion of approval by the Ethics Committee, thus covering the months of January, February and March 2020.

When clicking on the link, on the first page, there was the Free and Informed Consent Term. After reading it, the participant expressed her acceptance by clicking on the "I agree to

participate" option. Subsequently, the questionnaire was available to be answered, and the participant had to click on the "send" option when responding to participate.

Data analysis took place in two ways: multiple choice responses, which correspond to statistical data, were analyzed using simple descriptive statistics. While the answers to the open-ended questions were treated by the content analysis proposed by Bardin, comprising the phases of pre-analysis, exploration of the material and treatment of the results[8].

Preserving the commitment to confidentiality and anonymity, the participants were identified by the initial "P", for "Participants", followed by the order number of the interview (P1, P2, P3...). The research respected the ethical precepts, according to Resolution 510/2016 of the Brazilian National Health Council, obtaining an opinion approved on December 12, 2019 under nº 3.766.225 and C.A.A.E. no. 26421419.1.0000.5324.

RESULTS

163 women participated, of which 110 declared themselves to be bisexuals and 53 lesbians. Most were between 18 and 29 years old (93.87%), followed by 30 and 39 years old (4.29%) and 40 and 49 (1.84%), and 140 were undergraduate students, and 15 were graduate students. Regarding the choice to inform or not inform about sexual orientation in health care, 57% answered that they informed it depending on the context, 28.83% chose not to inform it, 11.04% chose to always inform it, and 3.07% did not inform it anymore.

It was identified that 42.94% stopped attending places because of their sexuality, especially churches, clinics, family homes, bars and parties, especially when the public is mostly heterosexual. The main reasons for not attending these places were fear, prejudice, not feeling safe or free, in addition to reporting fetishization by men.

The support network was made up of friends, professionals and family members for both bisexual women and lesbians, with no great distinction between orientations. Still, 7.36% reported not having a support network.

73.62% of participants believe heteronormativity influences health in, 19.3% did not know how to respond and 6.75% believed there was no interference. Two categories were constructed: "*The perception of heteronormativity and the cultural, social and political implications for health*" and "*Heteronormativity and the personal implications for health*".

The perception of heteronormativity and the cultural, social and political implications for health

There was emphasis on the social and cultural standard impositions, which establisheswhat is accepted as the only possible normal for men and women within society:

The immediate assumption of one's sexuality, the definition of "male" and "female" behavior and personality patterns based on straight, patriarchal and sexist relationships. (P45)

Gender roles and social expectations were identified in establishing an appropriate and expected way of dressing, behaving, acting and thinking, with the establishment of standards from childhood and fostered through social relationships:

Social norms in which heterosexuality is considered the only possible form of normal, as well as the personification of gender based on feminine and masculine standards, that is, women must be feminine and men masculine, according to the norm. Heteronormativity, like any social structure, is present in all social aspects, such as children's games, entertainment in general, social relationships... (P120)

Gender and behavioral patterns that standard society understands to be "normal", for example boys' clothing and girls' clothing. Blue is for boys and pink for girls. In addition, heteronormativity imposes that women should not wear "men's" clothes and things and vice versa. There is also a pattern of behavior, since young boys are influenced to like girls and vice versa. (P2)

This gender role is premeditated by heteronormativity, including within homosexual relationships, presupposing a hierarchical system of power, also implying stigmatization as women who just haven't found the ideal man:

A pattern that tries to fit us into everything that is straight, like asking who is the "man" in a lesbian relationship, or discrediting lesbian women, thinking they haven't found their ideal man or that you can only have pleasure with a penis. (P141)

[...] *In relationships between women, in turn, many of these behaviors are reproduced directly or indirectly, as in a couple in which one of the women does not perform femininity and the other does, it is expected that the non-feminized woman assumes the role of strength and provider of the home.* (P41)

Heteronormativity can be evidenced even in public policies, in which the participants expressed that they do not feel covered. Also, they also reported less visibility of women who have relationships with other women in documents and a detachment from their applicability in health care:

There is a great shortage of information and it seems more like an information booklet for society than something aimed at the health of LGBT people, moreover, gay men, for being men and cisgender within a heteronormative society always have larger "prominence". In other words, lesbian women are hardly ever mentioned, as there is a (social and personal) stigma on women's sexuality within society. (P35)

I think the National LGBT Health Policy is a very important milestone in the fight for equal rights, but unfortunately, professionals are not adequately trained to care for LGBT individuals. (P36)

Heteronormativity and the personal implications for health

When establishing a standard of normality, the social impositions to be followed generate damage to mental or physical health. In mental health, there are losses to the extent that they feel out of social norm, which generates suffering and the understanding that their sexual orientation is made invisible:

My mental health, because from the moment bisexuality is treated as something different, where there is no visibility, heteronormativity is imposed. This caused me crises of anxiety and depression for not "fitting in" what was expected of women and society's standard. (P86)

Because I'm not straight, theoretically, I don't fit into any of the "laws" that our society is based on, such as religious beliefs. In addition to being considered a "rebel" for not following tradition... of patriarchy, for example. So, all those who deviate from this imposed standard seem as the right one, suffer [...]. (P28)

It was identified that social sex education is aimed at phallocentric sex, in which the normal and expected of a woman is to have sexual relationships with men. Also, health is affected by not feeling contemplated and represented in advertising campaigns or even by being neglected in health services, since professionals do not have enough knowledge to attend to them:

Heteronormativity causes STI prevention campaigns to exclude lesbian sex, for example, as they do not even consider/legitimize the relationship between two women as sex. In the absence of penetration of a penis in a vagina, some gynecologists, when we report having homosexual relations, even exempt us of some routine exams. I say this because I have already experienced it. (P127)

All gynecological exams are done as if I only have sex with men, even the questions at the clinic. Also, sex education for lesbians is abysmal, as are STI prevention materials. To this day I don't know how to effectively protect myself when I have relationships with girls. (P112)

Heteronormativity directly influences gynecological health, as they identified professional unpreparedness in care related to STI prevention methods:

I'm a lesbian woman, and when I go to the gynecologist, she never knows how to treat me, precisely because condoms and contraceptives don't work for me. There is no anti-STI contraceptive created for women who have relationships with women. (P120)

Barrier methods for STI prevention were considered important for lesbian and bisexual women, however, they emphasized that they are not specific to their needs, but rather to the heterosexual audience:

Ineffective and super uncomfortable. It is not designed for lesbians and bisexual women. It's an improvised form of prevention that can go wrong. (P23)
I think it's important, but the [methods] *I know are terrible. I protect myself in sexual relations with men, but never with women.* (P78)

They recognized that talking about sex between women and ways to prevent STIs is taboo, even within the LGBT+ community, and there is a lot of misinformation about ways to prevent it:

I think it's taboo for some [women]. *A lot of people think they don't need to put a condom on their finger, for example. I also don't know how to perform oral sex with a condom.* (P66)
As I said before, there is no lesbocentric sex education. Within the lesbian community there is the false and prejudiced impression that lesbians do not transmit STIs, that any disease comes from bisexual women ("those promiscuous ones") who have relationships with men. This is the first taboo to be broken. Due to this culture, using condoms, gloves and dental dams is very frowned upon, it is as if it was offensive to the partner, as if she was dirty. In addition, children and adolescents are never taught the importance of condoms in oral sex. (P73)

Questions were raised about the real desire to have children, relating it to the social pressure imposed by heteronormativity, facing the role of women. The desire to build a family or not is part of the desires of the participants, with different motivations:

I was told it is the cycle of life. But I don't know if this comes from me or if it is imposed, because I don't see myself being a mother. (P113)
I think babies are very cute and I love children, but being a mother is giving up a freedom that I struggled a lot to have, so no. (P43)
I don't see myself emotionally capable of being a mother. (P151)
Yes, because, first, there is social pressure from the role of women as mothers and, second, for personal satisfaction. Building a family could be a future project. (P89)
Yes, I would like to raise a child and be able to teach them about the world. (P129)
Not. I want to focus more on my professional goals and I don't want to put a child in this bad world. If I had a child, I would adopt. (P24)

DISCUSSION

Sexuality is considered a fundamental part of people's lives, including several aspects, such as: sex, gender identity, sexual orientation and also motherhood[9]. At the individual level, LGBT+ people experience heteronormativity, that is, the prevailing social assumption that everyone is heterosexual. Heteronormativity is present in society as a whole, including in health environments, where sexual minorities also need access to services[10].

The difficulty of bisexual women and lesbians in revealing their sexual orientation in health services, on the one hand, and the assumption of professionals about the heterosexuality

of patients, on the other, create obstacles to communication, which explain how heteronormativity occurs in practice. In this light, LGBT+ people obtain greater social acceptance when they meet heteronormative standards[9].

When accessing health services, it was found that most participants choose to inform their sexual orientation, so that, in some cases, clinics are among the places they stop attending because they do not feel welcomed. Another investigation also highlights the fear of stigma and discrimination as an important factor for the removal of this population from health services, especially public ones, since there is a preference for private services[11].

This preference for private services shows the absence or incompleteness of public policies that make the demand and health of bisexual women and lesbians invisible, resulting in physical and psychological health problems. Several studies show that sexual minorities are more exposed to excessive consumption of alcohol and tobacco[12-14], in addition to being more likely to report experiences of victimization and threats of aggression, identifying a greater risk for anxiety, mood swings, stress, depression and substance use when compared to heterosexuals[12]. Lesbian and bisexual invisibility in health care spaces, professional unpreparedness and the consequent evasion of this population in these contexts impair the identification and management of these diseases[15].

The support network mentioned was predominantly friends and professionals, demonstrating that the family or intimate unit does not work as a support and protection network, which can potentiate the damage caused by social discrimination experienced in public spaces[16].

In sexual and reproductive health, many women still do not have access to information about the specifics of sexual protection, and therefore, how to effectively take care of their health[18]. In Resolution No. 614/2019, the Brazilian National Health Council affirms the guarantee of comprehensive health care for women and LGBT+ people, however, stereotyped ideas that consider bisexuality as supposed promiscuity of these people, transitory identity or indecision, show the abjection of these bodies, when health professionals do not understand this way of experiencing sexuality as legitimate to access some type of care[17].

A survey carried out in Brazil found that, when compared to women who have sex with men and women, women who exclusively have sex with women were less likely to go to the gynecologist[18]. When these women seek services, they receive less guidance or no guidance at all on STIs and other sexual instructions[5,18]. In addition, when informed, misconceptions are disseminated, such as invulnerability to contract STIs[6].

The lack of discussion on the part of professionals on the subject also affects the knowledge of women themselves about their sexual health, so that studies report a disregard for prevention, either because they consider the risk of transmission of STIs in sex between women to be low or non-existent, or due to the lack of knowledge of possible preventive methods[19-20].

In addition to the irregular attendance to the gynecologist, many women are afraid to expose their sexual orientation in medical consultations, leading to a lack of recognition of sexual practices and, therefore, wrong referrals in relation to exams and preventive methods or not requesting important exams, such as rapid STI tests and pap smears[21]. Also, women, in general, are not encouraged by health professionals to verbalize their sexual orientations. Therefore, it is important for the professional to be aware of the sexual orientation of each woman, in order to reduce the heteronormative emphasis on care and, thus, understand the risks and injuries that might go unnoticed, exercising health education on relevant issues[10].

Another survey showed that 49.33% of bisexual women and lesbians reported not using latex gloves, 49% did not use dental dams and 66% had never used condoms for oral sex. Still, only 32.67% reported using personal toys without sharing them[11], as well as using less barrier methods during sex when compared to heterosexual women[13,22]. These findings increase health risk factors, such as the occurrence of cervical cancer, since there is a 53% prevalence of any type of human papillomavirus in women of sexual minorities, so that women with five or more partners sexual intercourse during life are more likely to be infected[23].

With the scarcity of their own methods and the lack of access to prevention information, many women seek guidance in online spaces of the LGBT+ community or in their personal relationships[24]. Thus, despite the taboo that exists on this topic, certain preventive behaviors and methods are encouraged, such as: hand washing and nail clipping; adaptation of male condoms and use of tongue condoms; use of disposable gloves/latex gloves and topical antimicrobial gel solutions; use of male condoms in sex toys and subsequent cleaning; use of dental dams, plastic wrap and female condom; performing STI tests and routine exams; and avoid oral sex during menstruation[24].

Women tend to treat means of prevention with strangeness and distrust, either because they do not consider adequate and specific methods for sexual practices between women or because they do not feel interested in using them, as they consider them adaptations, such as the male condom without lubrication, or items that would originally be used for something else entirely (PVC plastic film, surgical gloves, latex barrier for dental use). In view of this, there is an urgent need for public policies, research and partnerships for the development of inputs to

be used in relationships between women, because insofar as there are no specific preventive methods for the prevention of STIs, there is no way to consider the use of alternative means in prevention, as there are doubt about the effectiveness and safety of these items[5].

The scenario of inadequate care in reproductive planning can lead to discrepancies between women's sexual practices and their contraceptive behaviors, since women's contraception is often not supported by an individual and informed choice, leading them, consequently, to using contraceptive methods that do not correspond to their reproductive practices and their desire to become pregnant[25], considering that the desire to extend the family does not differ from heteroparental families[9].

Compared to heterosexuals, lesbians, gays and bisexuals expressed less desire to have children. They also predicted more stigma as parents than heterosexuals[26]. In general, lesbian women report less favorable experiences with babies and/or children, with more social and economic costs involved, than heterosexual women[27].

The approach in health services is centered on the care of heterosexual couples/families, since, from the reproductive point of view, these are the couples capable of constituting, morally and culturally, a family nucleus. Thus, the need for family planning for same-sex couples should be an essential element in primary health care, as well as for heterosexual couples. Allowing them access to information and health services, as well as the provision of care, prevention and health promotion, including sexual and reproductive health[28].

The experience in health spaces does not refer to comprehensive, humanized and ethical care, but is often anchored in the lack of awareness and secrecy of health professionals. Also, there is insecurity in approaching LGBT+ people, as a result of the lack of specific training in undergraduate health courses, as well as permanent education[29]. Furthermore, there is a need to formulate and implement articulated laws, policies, regulations and codes of conduct, in addition to transparent procedures and practices to guarantee equal rights of access and treatment in health services[10].

CONCLUSION

It was found that most bisexual women and lesbians in university believed that heteronormativity influenced their health, even though the verbalization of their sexual orientation in the consultations is predominant among them. As a result, many reported not attending places, including health services, due to their sexuality, whether due to fear, discrimination or insecurity.

Bisexual women and lesbians feel invisible in public health policies, generating psychological and physical consequences, such as anxiety, depression and repercussions on their sexual health. There is unpreparedness of professionals and lack of advertising campaigns, made visible by insufficient knowledge about the sexual and reproductive issues of bisexual women and lesbian, including the issue of STI prevention, given that this area is exclusively focused on heterosexual demands.

Due to the fact that the research was carried out over the internet, despite facilitating accessibility and reach of the public, it also did not have an answer to all questions, characterizing itself as a limitation of the study. Despite this, the scarcity of studies brings contributions in this investigation. In turn, more studies with other designs and of greater amplitude, as well as regulations and public policies are needed aimed at lesbian and bisexual women.

REFERENCES

1. Aufranc ALB. Expressões da sexualidade: um olhar junguiano. Junguiana [Internet]. 2018 [cited in 15 Nov 2021]; 6(1):37-48. Available from: http://pepsic.bvsalud.org/pdf/jung/v36n1/07.pdf
2. Lúcio FPS, Zerbinati JP, Bruns MAT, Souza CRV. Saúde sexual da mulher lésbica e/ou bissexual: especificidades para o cuidado à saúde e educação sexual. Revista Ibero-Americana de Estudos em Educação [Internet]. 2019 Jul [cited in 25 Nov 2021];14(N Esp 2):1465-79. DOI: 10.21723/riaee.v14iesp.2.12611
3. Oliveira EL, Rezende JM, Gonçalves JP. História da sexualidade feminina no Brasil: entre tabus, mitos e verdades. Revista Ártemis [Internet]. 2018 [cited in 25 Nov 2021]; 26(1):303-14. DOI: 10.22478/ufpb.1807-8214.2018v26n1.37320
4. Choucair TS, Lopes PC. Numa luta marginalizada não cabe uma atuação tradicional: a caminhada das lésbicas e bissexuais de Belo Horizonte. Revista Periódicus [Internet]. 2017 [cited in 04 Dec 2021]; 1(7):54-77. DOI: 10.9771/peri.v1i7.21670
5. Lima MAS, Saldanha AAW. (In)visibilidade lésbica na saúde: análise de fatores de vulnerabilidade no cuidado em saúde sexual de lésbicas. Psicol Ciênc Prof. [Internet]. 2020 [cited in 04 Dec 2021]; 40:e202845. DOI: 10.1590/1982-3703003202845
6. Cabral KTF, Pereira IL, Almeida LR; Nogueira WBAG, Silva FV, Costa LFP, et al. Nursing care for lesbian and bisexual women. Rev Enferm UFPE on line [Internet]. 2019 Jan [cited in 15 Nov 2021]; 13(1):79-85. DOI: 10.5205/1981-8963-v13i01a237896p79-85-2018
7. Nogueira FJS, Aragão TAP. Política Nacional de Saúde Integral LGBT: o que ocorre na prática sob o prisma de usuários (as) e profissionais de saúde. Saúde e Pesqui. [Internet]. 2019 set/dez [cited in 04 Dec 2021]; 12(3):463-70. DOI: 10.17765/2176-9206.2019v12n3p463-470
8. Bardin L. Análise de Conteúdo. São Paulo: Edições 70; 2016. 141 p.
9. Videla CF, Muñoz AV. Vivencias de usuarias lesbianas sobre el proceso de atención perinatal en la región metropolitana, Chile en 2016. Interface Comun Saúde Educ. [Internet]. 2018 Jul/Sept [cited in 17 Nov 2021]; 22(66):777-87. DOI: 10.1590/1807-57622017.0254
10. Suen YT, Chan RCH. A nationwide cross-sectional study of 15,611 lesbian, gay and bisexual people in China: disclosure of sexual orientation and experiences of negative treatment in health care. Int J Equity Health [Internet]. 2020 [cited in 17 Nov 2021]; 19:46. DOI: 10.1186/s12939-020-1151-7

11. Logie CH, Marcus N, Wang Y, Duncan AL, Levermore K, Jones N, et al. Contextualising sexual health practices among lesbian and bisexual women in Jamaica: a multi-methods study. Reprod Health Matters [Internet]. 2018 Dec [cited in 04 Dec 2021]; 26(52):1517543. DOI: 10.1080/09688080.2018.1517543
12. Caceres BA, Brody AA, Halkitis PN, Dorsen C, Yu G, Chyun DA. Cardiovascular disease risk in sexual minority women (18-59 Years Old): findings from the National Health and Nutrition Examination Survey (2001-2012). Women's Health Issues [Internet]. 2018 Jul/Aug [cited in 04 Dec 2021]; 28(4):333-41. DOI: 10.1016/j.whi.2018.03.004
13. Lunn MR, Wanjun C, Zack MM, Thompson WW, Blank MB, Yehia BR. Sociodemographic characteristics and health outcomes among lesbian, gay, and bisexual U.S. adults using healthy people 2020 leading health indicators. LGBT Health [Internet]. 2017 Aug [cited in 25 Nov 2021]; 4(4):283-94. DOI: 10.1089/lgbt.2016.0087
14. Dai H. Tobacco product use among lesbian, gay, and bisexual adolescents. Pediatrics [Internet]. 2017 Apr [cited in 15 Nov 2021]; 139(4):e20163276. DOI: 10.1542/peds.2016-3276
15. Alves IG, Moreira LE, Prado MAM. Saúde de mulheres lésbicas e bissexuais: política, movimento e heteronormatividade. Rev Psicol Saúde [Internet]. 2020 jul/set [cited in 04 Dec 2021]; 12(3):145-61. DOI: 10.20435/pssa.vi.1072
16. Pinto IV, Andrade SSA, Rodrigues LL, Santos MAS, Marinho MMA, Benício LA, et al. Profile of notification of violence against Lesbian, Gay, Bisexual, Transvestite and Transsexual people recorded in the National Information System on Notifiable Diseases, Brazil, 2015-2017. Rev Bras Epidemiol. [Internet]. 2020 [cited in 04 Dec 2021]; 23(Supl 1):e200006. DOI: 10.1590/1980-549720200006.supl.1
17. Fernandes M. O movimento das mulheres lésbicas feministas no Brasil. Revista Cult [Internet]. 2018 [cited in 04 Dec 2021]; 235. Available from: https://revistacult.uol.com.br/home/mulheres-lesbicas-feministas-brasil/
18. Rufino AC, Madeiro A, Trinidad A, Santos R, Freitas I. Práticas sexuais e cuidados em saúde de mulheres que fazem sexo com mulheres: 2013-2014. Epidemiol Serv Saúde [Internet]. 2018 [cited in 15 Nov 2021]; 27(4):e2017499. DOI: 10.5123/s1679-49742018000400005
19. Doull M, Wolowic J, Saewyc E, Rosario M, Prescott T, Ybarra ML. Why girls choose not to use barriers to prevent sexually transmitted infection during female-to-female sex. J Adolesc Health [Internet]. 2017 Apr [cited in 15 Nov 2021]; 62(4):411-6. DOI: 10.1016/j.jadohealth.2017.10.005
20. Dal Santo A, Zambenedetti G. Prevenção às ISTs/HIV entre mulheres lésbicas e bissexuais: uma revisão bibliográfica (2013-2017). Psi UNISC. [Internet]. 2021 [cited in 25 Nov 2021]; 5(1):111-26. DOI: 10.17058/psiunisc.v5i1.14846
21. Agénor M, Muzny CA, Schick V, Austin EL, Potter J. Sexual orientation and sexual health services utilization among women in the United States. Prev Med. [Internet]. 2017 Feb [cited in 04 Dec 2021]; 95:74-81. DOI: 10.1016/j.ypmed.2016.11.023
22. Barnhill M, Lee J, Rafferty A. Health Inequities among lesbian, gay, and bisexual adults in North Carolina, 2011-2014. Int J Environ Res Public Health [Internet]. 2017 Jul [cited in 15 Nov 2021]; 14(8):835-44. DOI: 10.3390/ijerph14080835
23. Branstetter AJ, Mcree AL, Reiter PL. Correlates of human papillomavirus infection among a national sample of sexual minority women. J Womens Health (Larchmt.) [Internet]. 2017 Sep [cited in 02 Dec 2021]; 26(9):1004-11. DOI: 10.1089/jwh.2016.6177
24. Batista MCH, Zambenedetti G. Uma pesquisa-intervenção sobre prevenção às IST/HIV com mulheres lésbicas e bissexuais. Psicol Pesq. [Internet]. 2017 jul/dez [cited in 02 Dec 2021]; 11(2):42-50. DOI: 10.24879/2017001100200180
25. Melo CRM, Borges ALV, Duarte LS, Nascimento NC. Contraceptive use and the intention to become pregnant among women attending the Brazilian Unified Health System. Rev LatinoAm

Enferm. [Internet]. 2020 [cited in 15 Nov 2021]; 28:e3328. DOI: 10.1590/1518-8345.3451.3328
26. Leal D, Gato J, Tasker F. Prospective parenting: sexual identity and intercultural trajectories. Cult Health Sex. [Internet]. 2019 Jul [cited in 04 Dec 2021]; 21(7):757-73. DOI: 10.1080/13691058.2018.1515987
27. Tate DP, Patterson CJ. Sexual minority women's attitudes toward infants, children, and parenthood. J Lesbian Stud. [Internet]. 2019 [cited in 04 Dec 2021]; 23(4):464-75. DOI: 10.1080/10894160.2019.1629807
28. Albuquerque GA, Belém JM, Nunes JFC, Leite MF, Quirino GS. Planejamento reprodutivo em casais homossexuais na estratégia saúde da família. Rev APS. [Internet]. 2018 jan/mar [cited in 25 Nov 2021]; 21(1):104-11. DOI: 10.34019/1809-8363.2018.v21.15639
29. Silva ACA, Alcântara AM, Oliveira DC, Signorelli MC. Implementação da Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais (PNSI LGBT) no Paraná, Brasil. Interface Comun Saúde Educ. [Internet]. 2020 [cited in 25 Nov 2021]; 24:e190568. DOI: 10.1590/interface.190568

Associated Published: Rafael Gomes Ditterich.

Conflict of Interests: the authors declared there is no conflict of interests.

Financing: none.

CONTRIBUTIONS
Naiara Regner da Silva and **Camila Daiane Silva** contributed to the design, collection and analysis of data and writing. **Marina Soares Mota**, **Luís Felipe Hatje**, **Victoria Leslyê Rocha Gutmann** and **Carolina Coutinho Costa Vallejos** participated in the writing and revision.

How to cite this article (Vancouver)
Silva NR, Mota MS, Hatje LF, Gutmann VLR, Vallejos CCC, Silva CD. Heteronormativity and the health of bisexual women and lesbians in university. Rev Fam, Ciclos Vida Saúde Contexto Soc. [Internet]. 2022 [cited in *insert day, month and year of access*]; 10(3):501-14. Available from: *insert access link*. DOI: *insert DOI link*.

How to cite this article (ABNT)
SILVA, N. R. da; MOTA, M. S.; HATJE, L. F.; GUTMANN, V. L. R.; VALLEJOS, C. C. C.; SILVA, C. D. Heteronormativity and the health of bisexual women and lesbians in university. **Rev. Fam., Ciclos Vida Saúde Contexto Soc.**, Uberaba, MG, v. 10, n. 3, p. 501-514, 2022. DOI: *insert DOI link*. Available from: *insert access link*. Access in: *insert day, month and year of access*.

How to cite this article (APA)
Silva, N. R., Mota, M.S., Hatje, L.F., Gutmann, V.L.R., Vallejos, C.C.C., & Silva, C.D. (2022). Heteronormativity and the health of bisexual women and lesbians in university. *Rev. Fam., Ciclos Vida Saúde Contexto Soc.*, 10(3), 501-514. Retrieved in *insert day, month and year of access* from *insert access link*. DOI: *insert DOI link*.